FILED SENATE
Mar 27, 2013
S.B. 473
PRINCIPAL CLERK

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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SENATE DRS15110-MGx-29G (01/14)

Short Title:	HealthCare Cost Reduction & Transparency.	(Public)
Sponsors:	Senators Rucho and Brown (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO IMPROVE TRANSPARENCY IN THE COST OF HEALTH CARE PROVIDED BY HOSPITALS AND AMBULATORY SURGICAL FACILITIES; TO TERMINATE SET-OFF DEBT COLLECTION BY CERTAIN STATE AGENCIES PROVIDING HEALTH CARE TO THE PUBLIC; TO PROHIBIT HOSPITALS AND AMBULATORY SURGICAL FACILITIES FROM CHARGING MULTIPLE TIMES FOR OUTPATIENT RADIOLOGY SERVICES RENDERED ONLY ONCE; TO MODIFY THE HOSPITAL PROVIDER ASSESSMENT ACT; AND TO ENCOURAGE COMMUNITY CARE OF NORTH CAROLINA TO ADJUST ITS CORPORATE GOVERNANCE.

The General Assembly of North Carolina enacts:

PART I. TITLE

SECTION 1. This act shall be known as the Health Care Cost Reduction and Transparency Act of 2013.

PART II. TRANSPARENCY IN HEALTH CARE COSTS

SECTION 2. G.S. 90-413.2 reads as rewritten:

"**§ 90-413.2. Purpose.**

This Article is intended to improve the quality of health care delivery within this State by facilitating and regulating the use of a voluntary, statewide health information exchange network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses in a manner that is consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164. This Article is also intended to improve transparency in health care costs by providing information to the public on the cost of the 50 most common episodes of care in hospitals subject to the North Carolina Hospital Licensure Act and ambulatory surgical facilities subject to the North Carolina Ambulatory Surgical Facility Licensure Act."

SECTION 3. Article 29A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-413.9. Disclosure of prices for most common episodes of care.**

The NC HIE shall provide free public access to the most current information it receives from hospitals and ambulatory surgical facilities pursuant to G.S. 131E-91.1 and G.S. 131E-153 on an Internet Web site established and maintained by the NC HIE that is

available to the general public. The NC HIE shall provide this information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each hospital shall be listed separately, and hospitals shall be listed in groups by category, as determined by the North Carolina Medical Care Commission in rules adopted pursuant to G.S. 131E-91.1.

(2) Information for each ambulatory surgical facility shall be listed separately.

(3) Information concerning the most common episodes of care for each hospital shall include a separate listing of the facility fees charged by health care providers affiliated with the hospital.

(4) Information concerning the most common episodes of care for each ambulatory surgical facility shall include a separate listing of the facility fees charged by health care providers affiliated with the facility."

SECTION 4. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 4A. Transparency in Health Care Costs.

"**§ 131E-91.1. Disclosure of prices for most common episodes of care.**

(a) The following definitions apply in this section:

(1) Episode of care. – All acute care hospital services related to a health condition with a given diagnosis, from the three-day period preceding a patient's first admission to a hospital, including readmissions, through the 30-day period following the patient's discharge from the hospital, for treatment of the health condition. The term includes acute care hospital services, services by health care providers affiliated with the hospital, facility use by health care providers affiliated with the hospital, ancillary services, room and board, and pharmaceuticals.

(2) Health insurer. – As defined in G.S. 108A-55.4.

(3) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Annually on January 1, beginning January 1, 2014, each hospital licensed pursuant to this Article shall provide to the North Carolina Health Information Exchange, utilizing electronic health records software, the following information about the hospital's 50 most common episodes of care:

(1) The amount that will be charged to a patient for each episode of care if all charges are paid in full without a public or private third party paying for any portion of the charges, along with a separate listing of the facility fees charged by health care providers affiliated with the hospital for each episode of care.

(2) The total amount of Medicaid reimbursements for each episode of care.

(3) The total amount of Medicare reimbursements for each episode of care.

(4) For each of the five largest health insurers providing payment to the hospital on behalf of insureds, the range of the total amount of payments made by each health insurer for each episode of care. Prior to providing this information to the NC HIE, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

(5) The total amount of payments made by the State Health Plan for Teachers and State Employees for each episode of care.

(c) Upon request of a patient, a hospital shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.

(d) The disclosure requirements of this section shall not be construed to require a hospital licensed pursuant to this Article to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.

(e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that hospitals report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include all of the following:

(1) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the NC HIE Internet Web site.

(2) To the extent practicable, methods to ensure that hospitals report information about the most common episodes of care from a cross section of medical and surgical specialty areas identified by the Commission.

"**§ 131E-91.2. Disclosure of charity care information.**

(a) As used in this section, "charity care" means the costs to the hospital of providing health care or other services to a patient who is uninsured or otherwise unable to pay for all services rendered.

(b) Annually on January 1, beginning January 1, 2014, each operator of a hospital shall conspicuously post the hospital policy on charity care and the amount spent by the hospital on charity care during the preceding calendar year in the following locations:

(1) On the licensed premises in an area accessible to the public.

(2) On an Internet Web site established and maintained by the hospital and made available to the general public."

SECTION 5. G.S. 131E-91, currently codified in Part 4 of Article 5 of Chapter 131E of the General Statutes, is recodified in Part 4A of Article 5 of Chapter 131E of the General Statutes and reads as rewritten:

"**§ 131E-91. Itemized charges on discharged patient's bill.**

(a) All hospitals ~~and ambulatory surgical facilities~~ licensed pursuant to this ~~Chapter~~ Article shall, upon request of the patient within 30 days ~~of~~ after discharge, present an itemized list of charges to all discharged patients.

(b) The Commission shall adopt rules to ensure that this section is properly implemented and that patient bills which are not itemized include notification to the patient of ~~his~~ the right to request an itemized bill. The Department shall not issue ~~nor~~ or renew a license under this ~~Chapter~~ Article unless the applicant has demonstrated that the requirements of this section are being met."

SECTION 6. Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding new sections to read:

"**§ 131E-153. Itemized charges on discharged patient's bill.**

(a) All ambulatory surgical facilities licensed pursuant to this Part shall, upon request of the patient within 30 days after discharge, present an itemized list of charges to all discharged patients.

(b) The Commission shall adopt rules to ensure that this section is properly implemented and that patient bills which are not itemized include notification to the patient of the right to request an itemized bill. The Department shall not issue or renew a license under this Part unless the applicant has demonstrated that the requirements of this section are being met.

"**§ 131E-153.1. Disclosure of prices for most common episodes of care.**

(a) The following definitions apply in this section:

(1) Episode of care. – All ambulatory surgical services related to a health condition with a given diagnosis, from the three-day period preceding a patient's first admission to an ambulatory surgical facility, including

readmissions, through the seven-day period following the patient's discharge from the facility, for treatment of the health condition. The term includes ambulatory surgical services, services by health care providers affiliated with the facility, facility use by health care providers affiliated with the facility, use of facility operating and recovery rooms, and pharmaceuticals.

(2) Health insurer. – As defined in G.S. 108A-55.4.

(3) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Annually on January 1, beginning January 1, 2014, each ambulatory surgical facility licensed pursuant to this Part shall provide to the North Carolina Health Information Exchange, utilizing electronic health records software, the following information about the facility's 50 most common episodes of care:

(1) The amount that will be charged to a patient for each episode of care if all charges are paid in full without a public or private third party paying for any portion of the charges, along with a separate listing of the facility fees charged by health care providers affiliated with the hospital for each episode of care.

(2) The total amount of Medicaid reimbursements for each episode of care.

(3) The total amount of Medicare reimbursements for each episode of care.

(4) For each of the five largest health insurers providing payment to the facility on behalf of insureds, the range of the total amount of payments made by each health insurer for each episode of care. Prior to providing this information to the NC HIE, each facility shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

(5) The total amount of payments made by the State Health Plan for Teachers and State Employees for each episode of care.

(c) Upon request of a patient, an ambulatory surgical facility shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.

(d) The disclosure requirements of this section shall not be construed to require an ambulatory surgical facility licensed pursuant to this Part to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.

(e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that ambulatory surgical facilities report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include, to the extent practicable, methods to ensure that ambulatory surgical facilities report information about the most common episodes of care from a cross section of medical and surgical specialty areas identified by the Commission.

"**§ 131E-153.2. Disclosure of charity care information.**

(a) As used in this section, "charity care" means the costs to the ambulatory surgical facility of providing health care or other services to a patient who is uninsured or otherwise unable to pay for all services rendered.

(b) Annually on January 1, beginning January 1, 2014, each operator of an ambulatory surgical facility shall conspicuously post the facility policy on charity care and the amount spent by the facility on charity care during the preceding calendar year in the following locations:

(1) On the licensed premises in an area accessible to the public.

(2) On an Internet Web site established and maintained by the ambulatory surgical facility and made available to the general public."

SECTION 7. Not later than July 1, 2013, the Department of Health and Human Services shall do all of the following:

(1) Communicate the requirements of Sections 3 and 4 of this act to all hospitals licensed pursuant to Article 5 of Chapter 131E of the General Statutes.

(2) Communicate the requirements of Sections 3 and 6 of this act to all ambulatory surgical facilities licensed pursuant to Part 4 of Article 6 of Chapter 131E of the General Statutes.

SECTION 8. G.S. 131E-97.3(a) reads as rewritten:

"**§ 131E-97.3. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of hospitals and public hospital authorities. Competitive health care information does not include any of the information hospitals are required to report under G.S. 131E-91.1 or any of the information ambulatory surgical facilities are required to report under G.S. 131E-153. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of a public hospital or public hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section."

SECTION 9. G.S. 131E-99 reads as rewritten:

"**§ 131E-99. Confidentiality of health care contracts.**

~~The~~ Except for the information a hospital is required to report under G.S. 131E-91.1 and the information an ambulatory surgical facility is required to report under G.S. 131E-153, the financial terms and other competitive health care information directly related to the financial terms in a health care services contract between a hospital or a medical school and a managed care organization, insurance company, employer, or other payer is confidential and not a public record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an elected public body which has responsibility for the hospital or medical school from having access to this confidential information in a closed session. The disclosure to a public body does not affect the confidentiality of the information. Members of the public body shall have a duty not to further disclose the confidential information."

PART III. TRANSPARENCY IN BILLING FOR OUTPATIENT RADIOLOGY SERVICES

SECTION 10. Part 4A of Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-91.3. Duplicate charges for certain radiology services prohibited.**

(a) The following definitions apply in this section:

(1) Clinical labor. – Includes all of the following:

a. Greeting the patient.

b. Escorting and positioning the patient for radiology services.

c. Educating the patient about the radiology services to be performed and obtaining the patient's informed consent for the services.

d. Retrieving the patient's prior examinations.

e. Setting up an intravenous line for the patient.

f. Preparing and cleaning the examination room.

g. Operating the radiology equipment.

(2) Multiple radiology session. – A single outpatient session during which multiple radiology imaging procedures are performed.

(3) Technical components. – The clinical labor and supplies used by a hospital to perform radiology imaging procedures on a patient, including gowns and contrast material. This term does not include X-ray film.

(b) It shall be unlawful for a hospital licensed under this Article, or a health care provider affiliated with the hospital, to charge a patient, entity, or person more than once for the full amount of the technical components of radiology imaging procedures performed on the patient during a multiple radiology session if the hospital or health care provider affiliated with the hospital only provides the technical components once during the multiple radiology session.

(c) Any contract provision or other agreement between a health insurer and a hospital licensed under this Article, or a health care provider affiliated with the hospital, that purports to require a party to pay for charges deemed unlawful under this section is void and unenforceable.

(d) Nothing in this section shall be construed to prohibit a hospital, or a health care provider affiliated with the hospital, from doing any of the following:

(1) Charging a patient, entity, or person for the full amount of the technical components of multiple radiology imaging procedures performed on the same day, but not during the same session.

(2) Submitting a corrected bill to a patient, entity, or person.

(3) Requesting the radiology services of more than one radiologist for a second medical opinion on a specimen."

SECTION 11. Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-153.3. Duplicate charges for certain radiology services prohibited.**

(a) The following definitions apply in this section:

(1) Clinical labor. – Includes all of the following:

a. Greeting the patient.

b. Escorting and positioning the patient for radiology services.

c. Educating the patient about the radiology services to be performed and obtaining the patient's informed consent for the services.

d. Retrieving the patient's prior examinations.

e. Setting up an intravenous line for the patient.

f. Preparing and cleaning the examination room.

g. Operating the radiology equipment.

(2) Multiple radiology session. – A single outpatient session during which multiple radiology imaging procedures are performed.

(3) Technical components. – The clinical labor and supplies used by a hospital to perform radiology imaging procedures on a patient, including gowns and contrast material. This term does not include X-ray film.

(b) It shall be unlawful for an ambulatory surgical facility licensed under this Part, or a health care provider affiliated with the facility, to charge a patient, entity, or person more than once for the full amount of the technical components of radiology imaging procedures performed on the patient during a multiple radiology session if the ambulatory surgical facility or health care provider affiliated with the facility only provides the technical components once during the multiple radiology session.

(c) Any contract provision or other agreement between a health insurer and an ambulatory surgical facility licensed under this Part, or a health care provider affiliated with the facility, that purports to require a party to pay for charges deemed unlawful under this section is void and unenforceable.

(d) Nothing in this section shall be construed to prohibit an ambulatory surgical facility, or a health care provider affiliated with the facility, from doing any of the following:

(1) Charging a patient, entity, or person for the full amount of the technical components of multiple radiology imaging procedures performed on the same day, but not during the same session.
(2) Submitting a corrected bill to a patient, entity, or person.
(3) Requesting the radiology services of more than one radiologist for a second medical opinion on a specimen."

PART IV. HOSPITAL DEBT COLLECTION

SECTION 12. G.S. 105A-2(9) reads as rewritten:

"(9) State agency. – Any of the following:
a. A unit of the executive, legislative, or judicial branch of State ~~government.~~government, except for the following:
1. Any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The University of North Carolina that provides medical care to the general public.
2. The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System.
b. A local agency, to the extent it administers a program supervised by the Department of Health and Human Services or it operates a Child Support Enforcement Program, enabled by Chapter 110, Article 9, and Title IV, Part D of the Social Security Act.
c. A community college."

PART V. HOSPITAL PROVIDER ASSESSMENTS

SECTION 13.(a) Article 7 of Chapter 108A of the General Statutes reads as rewritten:

"Article 7.
"Hospital Provider Assessment Act.

…

"**§ 108A-121. Definitions.**

The following definitions apply in this Article:

(1) CMS. – Centers for Medicare and Medicaid Services.
(2) Critical access hospital. – Defined in 42 C.F.R. § 400.202.
(3) Department. – The Department of Health and Human Services.
(4) Equity assessment. – The assessment payable under ~~G.S. 108A-123.~~G.S. 108A-123(b).
(5) Federal Medicaid match rate. – The Federal Medical Assistance Percentage rate for North Carolina.
~~(5) Medicaid equity payment. – The amount required to be paid under G.S. 108A-124.~~
(6) Public hospital. – A hospital that certifies its public expenditures to the Department pursuant to 42 C.F.R. § 433.51(b) during the fiscal year for which the assessment applies.
(7) Secretary. – The Secretary of ~~Health and Human Services.~~the Department.
(8) State's annual Medicaid payment. – ~~Forty-three million dollars ($43,000,000).~~The amount payable to the State under G.S. 108A-124(a)(1).
(9) State Medicaid match rate. – One hundred percent (100%) minus the Federal Medicaid match rate.

~~(9)~~(10) Total hospital costs. – The costs as calculated using the most recent available Hospital Cost Report Information Systems cost report data, available through CMS, or other comparable data.

~~(10)~~(11) Upper pay limit (UPL). – The maximum ceiling imposed by federal regulation on hospital Medicaid payments under 42 C.F.R. § 447.272 for inpatient services.

~~(11)~~(12) UPL assessment. – The assessment payable under ~~G.S. 108A-123.~~G.S. 108A-123(c).

~~(12)~~(13) UPL gap. – The difference between the UPL attributable to hospital inpatient services and the reasonable costs of inpatient hospital services as defined in Section (f)(2)(A) on page 11 of Attachment 4.19-A of the State Medicaid Plan as approved on December 15, 2005.

~~(13) UPL payment. – The amount required to be paid under G.S. 108A-124.~~

"**§ 108A-122. Assessment.**

(a) Assessment Imposed. – Except as provided in this section, the assessments authorized under this Article are imposed as a percentage of total hospital costs on all licensed North Carolina hospitals. The assessments are due quarterly in the time and manner prescribed by the Secretary. Payment of an assessment is considered delinquent if not paid within seven days of the due date. With respect to any past-due assessment, the Department may withhold the unpaid amount from Medicaid payments otherwise due or impose a late-payment penalty. The Secretary may waive a penalty for good cause shown.

(b) Allowable Cost. – An assessment paid under this Article may be included as allowable costs of a hospital for purposes of any applicable Medicaid reimbursement formula. An assessment imposed under this Article may not be added as a surtax or assessment on a patient's bill.

(c) Full Exemption. – The following hospitals are exempt from both the equity assessment and the UPL assessment:

(1) State-owned and State-operated hospitals.

(2) The primary affiliated teaching hospital for each University of North Carolina medical school.

(3) Critical access hospitals.

(4) Long-term care hospitals.

(5) Freestanding psychiatric hospitals.

(6) Freestanding rehabilitation hospitals.

(d) Partial Exemption. – A public hospital is exempt from the equity assessment.

(e) Assessment Collection. – Every assessment imposed by this Article shall become, from the time it is due and payable, a debt from the hospital liable to pay the same to the State of North Carolina. The Secretary of the Department of Health and Human Services shall report overdue assessments to the Secretary of the Department of Revenue who shall collect the debt using the collection remedies provided under Article 9 of Chapter 105 of the General Statutes.

"**§ 108A-123. Assessment amount.**

(a) Annual Calculation. – The Secretary must annually calculate the equity assessment amount and the UPL assessment amount for each hospital subject to the respective assessment. Each assessment must comply with applicable federal regulations and may be prorated for any partial year. The Secretary must notify each hospital that is assessed the amount of its UPL assessment and, if applicable, its equity assessment. The notice must include all of the following:

(1) The applicable assessment rates.

(2) The hospital costs on which the hospital's assessments are based.

(3) The elements of the calculation of the hospital's UPL.

(b) Equity Assessment. – The equity assessment consists of both inpatient and outpatient components. The equity assessment percentage rate must be calculated to produce an aggregate annual amount equal to the sum of the following:

(1) ~~The amount needed to make the Medicaid equity payments under G.S. 108-124.~~The State Medicaid match rate multiplied by the sum of Medicaid inpatient and outpatient deficits after calculating all other Medicaid payments, excluding disproportionate share hospital payments and any payments remitted to the hospitals under G.S. 108A-124(a)(2), for all hospitals subject to the equity assessment.

(2) The applicable portion of the ~~State's annual Medicaid payment, as~~ additional amount provided in subsection (d) of this section.

(c) UPL Assessment. – The UPL assessment consists of both inpatient and outpatient components. The UPL assessment percentage rate must be calculated to produce an aggregate annual amount equal to the sum of the following:

(1) ~~The amount needed to make the UPL payments under G.S. 108A-124.~~ The State Medicaid match rate multiplied by the sum of the UPL gaps for all hospitals subject to the UPL assessment.

(2) The applicable portion of the ~~State's annual Medicaid payment, as~~ additional amount provided in subsection (d) of this section.

(d) ~~State's Annual Medicaid Payment.~~ Additional Amount. – ~~The State's annual Medicaid payment~~ The sum of forty-three million dollars ($43,000,000) must be allocated between the equity assessment and the UPL assessment based on the amount of gross payments received by hospitals under G.S. 108A-124.

(e) Appeal. – A hospital may appeal an assessment determination through a reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation to pay an assessment amount when due.

(f) Assessment Limit. – Notwithstanding any other provision of this Article, the Secretary shall, if necessary, reduce a hospital's assessment so that the assessment does not exceed the percentage of gross revenue that would result in this Article imposing an impermissible health care-related tax, as defined under federal Medicaid law.

"**§ 108A-124. Use of assessment proceeds.**

(a) Use. – The proceeds of the assessments imposed under this Article and all corresponding matching federal funds must be used to make the State annual Medicaid payment to the State and ~~the Medicaid equity payments and UPL~~payments to ~~hospitals.~~hospitals as follows:

(1) Payment to State. – The sum of fifty million dollars ($50,000,000) shall be transferred to the Controller.

(2) Payments to hospitals. – After making the payment under subdivision (1) of this subsection, the Secretary shall allocate the remaining proceeds to hospital providers with low average monthly total Medicaid costs.

(b) Quarterly Payments. – Within seven days of the due date for each quarterly assessment imposed under G.S. 108A-123, the Secretary must ~~do the following:~~ transfer or pay twenty-five percent (25%) of the annual amounts provided in subsection (a) of this section to the respective payment recipients.

~~(1) Transfer to the State Controller twenty-five percent (25%) of the State's annual Medicaid payment amount.~~

~~(2) Pay to each hospital that has paid its equity assessment for the respective quarter twenty-five percent (25%) of its Medicaid equity payment amount. A hospital's Medicaid equity payment amount is the sum of the hospital's Medicaid inpatient and outpatient deficits after calculating all other Medicaid payments, excluding disproportionate share hospital payments and~~

~~the UPL payment remitted to the hospital under subdivision (3) of this subsection.~~

~~(3) Pay to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, to the critical access hospitals, and to each hospital that has paid its UPL assessment for the respective quarter twenty-five percent (25%) of its UPL payment amount, as determined under subsection (c) of this section.~~

(c) ~~UPL Payment Amount.~~ Restriction on Payments. – ~~The aggregate UPL payments made to eligible hospitals that are public hospitals is the sum of the UPL gaps for all public hospitals. The aggregate UPL payments made to eligible hospitals that are not public hospitals is the sum of the UPL gaps for these hospitals. UPL payments are payable to the individual hospitals in the ratio of each hospital's Medicaid inpatient costs to the total Medicaid inpatient costs for the respective group.~~Quarterly payments shall only be made to a hospital that has paid its assessments for the respective quarter.

(d) Refund of Assessment. – If all or any part of a payment required to be made under this section is not made to ~~one or more hospitals when due,~~ a hospital within one month after the quarterly assessments are due, the Secretary must promptly refund to each such hospital ~~the corresponding assessment proceeds collected in proportion to~~ the amount of assessment paid by that hospital.

…."

SECTION 13.(b) Pursuant to G.S. 108A-126, the Department of Health and Human Services shall file a State plan amendment with the Centers for Medicare and Medicaid Services that incorporates the assessment payments and distributions consistent with the amendments to the provisions of Article 7 of Chapter 108A of the General Statutes made by this section.

SECTION 13.(c) The Secretary of the Department of Health and Human Services shall develop the payment methodology under G.S. 108A-124(a)(2), as enacted by this section, in conjunction with the Office of Budget and Management and North Carolina Community Care Networks, Inc. (CCNC). Prior to making any payments under G.S. 108A-124(a)(2), as enacted by this section, the Secretary of the Department of Health and Human Services shall consult with the Joint Legislative Commission on Governmental Operations; such consultation shall occur no later than October 1, 2013.

PART VI. COMMUNITY CARE OF NORTH CAROLINA GOVERNANCE

SECTION 14.(a) The Department of Health and Human Services may not enter into a contract with North Carolina Community Care Networks, Inc., (CCNC) unless CCNC has made the governance changes provided in subsection (b) of this section.

SECTION 14.(b) North Carolina Community Care Networks, Inc., is encouraged to make, as soon as practicable, the following governance changes by amending its articles of incorporation, amending its bylaws, or taking other appropriate action:

(1) Adjust the board so as to contain the following:
   a. A health actuary.
   b. Two representatives of the provider community.
   c. One representative of the health insurance industry.
   d. Someone with expertise in health information technology, informatics, or performance measurement.
   e. A business owner.

(2) Adjust the board so as to provide for the following additional members:
   a. The Director of the Division of Medical Assistance.
   b. Two persons appointed by General Assembly on the recommendation of the President Pro Tempore.

c. Two persons appointed by the General Assembly on the recommendation of the Speaker of the House.
d. Two persons appointed by the Governor.

(3) Ensure that no members on its board directly benefit from the per member per month (PMPM) payments to participating providers.

(4) Ensure that no more than twenty-five percent (25%) of the members of the board are providers or come from the provider community.

(5) Ensure that the board size does not exceed 13 members.

PART VII. EFFECTIVE DATE

SECTION 15. Sections 8 and 9 of this act become effective January 1, 2014. Sections 10 and 11 of this act become effective July 1, 2013, and apply to outpatient radiology services provided, and contracts executed or renewed, on or after that date. Section 12 of this act becomes effective January 1, 2014, and applies to tax refunds determined by the Department of Revenue on or after that date. Section 13(a) of this act becomes effective July 1, 2013. The remainder of this act is effective when it becomes law.